

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

RECEIVED NOV 03 2005

Site Name & Number:

Staton 843

Site Phone #

(334) 567-1548

Site Fax #

(334) 567-1538

Patient Name: (Last, First,)

Mountain, Tony

Alias: (Last, First,)

Inmate #

152157 SCC

SS Number

418-98-7126

Date: (mm/dd/yy)

11/03/05

Date of Birth: (mm/dd/yy)

08/26/63

PHS Custody Date: (mm/dd/yy)

11/15/88

Potential Release Date: (mm/dd/yy)

07/07

Will there be a charge?

☒ Yes ☐ No

Sex


☒ Male ☐ Female

Responsible party:

☐ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider:

☐ Physician☐ NP, PA☐ Dental

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☒ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

Dr. Bradford

Type of Consultation, Treatment, Procedure or Surgery:

In house Eye Exam

Diagnosis:

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

Last Eye Exam 12/22/04

00 20/25

05 20/25

04 20/25

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.

Date resubmitted:

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

OPT code:

UR Auth #:

Usa - UM Referral review form

EXHIBIT

PENGAD 800-831-5989